UNICARE®

Personal Health Statemen

Section I - To Be Completed by Policyholder

POLICY / PLAN NO. _____ BILLING GROUP NO. _____ BILLING SUBGROUP / UNIT NO. _____ CLASS _____ EXISTING LIFE-IN-FORCE $

POLICYHOLDER (EMPLOYER) _____ CERT. NO. _____

NAME OF EMPLOYEE _____ DATE OF BIRTH _____ SEX ☐ M

EMPLOYEE'S HOME ADDRESS _____ LATE APPLICANT: ☐ YES

Section II - To Be Completed by Employee

	ANSWER YES OR NO	IF ANY PART IS ANSWERED "YES" GIVE PARTICULARS AND DATES
1. DO YOU HAVE ANY DISEASE OR AILMENT AT THE PRESENT TIME?		
2. IF THE ANSWER TO QUESTION NO. 1 IS "YES", DO YOU CONTEMPLATE OR HAS A PHYSICIAN RECOMMENDED AN OPERATION OR ANY MEDICAL TREATMENT FOR THIS CONDITION?		
3. DURING THE PAST FIVE YEARS HAVE YOU		
A. HAD ANY DISEASE OF THE KIDNEYS?		
B. BEEN ADVISED THAT YOU HAVE DIABETES? (IF YES, PROVIDE TYPE, MEDICATION AND DOSAGE)		
C. HAD ANY DISEASE OF THE HEART?		
D. BEEN ADVISED THAT YOU HAVE ABNORMAL BLOOD PRESSURE? (IF YES, PROVIDE TWO READINGS AND MEDICATIONS)		
E. HAD ANY DISEASE OF THE STOMACH OR BOWEL?		
F. HAD ANY DISEASE OF THE IMMUNE SYSTEM?		
G. HAD ANY DISEASE OF THE LUNGS?		
H. HAD ANY DISEASE OF THE NEUROLOGICAL SYSTEM?		
I. HAD ANY DISEASE OF THE GENITAL OR URINARY TRACT?		
J. HAD ANY DISEASE OF THE MUSCULO-SKELETAL SYSTEM?		
K. HAD ADVICE, ATTENDANCE OR TREATMENT BY A PHYSICIAN, PRACTITIONER OR ANY OTHER PERSON? (GIVE DATES AND REASON)		
L. HAD TREATMENT OR OBSERVATION IN A CLINIC, HOSPITAL OR RESIDENTIAL TREATMENT PROGRAM? (GIVE DATES AND REASON)		
4.A. HAVE YOU EVER APPLIED FOR LIFE, HEALTH OR ACCIDENT COVERAGE AND BEEN DECLINED, POSTPONED OR RESTRICTED, OR HAS A POLICY BEEN ISSUED AND AFTERWARDS CANCELLED?		
B. HAVE YOU EVER RECEIVED ANY INSURANCE BENEFITS OR COMPENSATION OF ANY KIND FOR ILLNESS OR INJURY?		

5. WHEN AND FOR WHAT DID YOU LAST CONSULT A PHYSICIAN? GIVE DATE, NAME AND ADDRESS OF PHYSICIAN OR PRACTITIONER, AND NATURE OF INJURY OR ILLNESS.

6. WHAT IS YOUR HEIGHT ____ FEET ____ INCHES, WEIGHT _____ POUNDS? 7. ARE YOU PREGNANT? ☐ YES ☐ NO

8. APPROVAL REQUESTED FOR FOLLOWING COVERAGES
☐ MEDICAL ☐ BASIC LIFE $_____ ☐ SUPP. LIFE ☐ LTD ☐ DRUGS ☐ EXEC. SUPP. ☐ VISION ☐ OTHER (specify) _____

TO THE BEST OF MY KNOWLEDGE AND BELIEF, THE FOREGOING STATEMENTS AND ANSWERS, EACH OF WHICH I HAVE MADE AND READ, ARE COMPLETE AND TRUE, ARE CORRECTLY AND FULLY RECORDED, AND NO MATERIAL CIRCUMSTANCES OR INFORMATION CONCERNING MY PAST AND PRESENT STATE OF HEALTH HAS BEEN OMITTED OR WITHHELD. I HEREBY DECLARE THAT A DUPLICATE COPY OF THIS INSTRUMENT CONTAINING THE ABOVE STATEMENTS OR ANSWERS TOGETHER WITH ANY EXPLANATIONS THERE TO HAS BEEN FURNISHED TO ME BY THE INSURANCE COMPANY.

WITNESS _____ ▶ SIGNATURE OF EMPLOYEE _____ DATE _____

PLEASE READ AND SIGN THE REVERSE SIDE OF THIS FORM

Section III - For UNICARE Use

Decision: ☐ Approved ☐ Declined ☐ Day 1 Plan ☐ Date Eligible Plan Date of Approval ____/____/____ Reviewed by _____ Regional Service Ctr. _____

If Declined, Reason: _____

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White - UNICARE Copy *Canary - Regional Service Center Copy* *Pink - Policyholder Copy*